Hiram W. Davis Medical Center
Petersburg, Virginia

Snapshot Inspection
November 15, 1999

Office of the Inspector General

Executive Summary:

This is a report of a snapshot inspection done at Hiram W. Davis Medical Center (HWDMC) on November 15, 1999. Snapshot inspections are brief unannounced inspections that have the following purpose: 1) review general conditions of the facility, 2) verify staffing presence and activity, 3) review general activity of the patients within a facility at that time, and 4) follow up on any other relevant previous concerns.

The following represents a summary of findings and would be taken out of context if interpreted without accompanying background information.

General Conditions

1.1 Finding: The front entrances to the building were not secured.

1.2 Finding: The facility was clean and well maintained, although there was not adequate storage space.

1.3 Finding: HWDMC has moved beds for CSH Forensics patients such that they are clustered together in one large room and may be more closely monitored as a group by the required 2:1 CSH Forensics staff.

Staffing Issues:

2.1 Finding: The use of mandatory overtime for facility staff has been reduced.

2.2 Finding: Staff reports that the response time for the on-call physician was good.

2.3 Finding: There was not any documented evidence of consultation by the psychiatrist from Central State Hospital regarding a long-term patient transferred from that facility to an acute bed.

2.4 Finding: HWDMC is currently using a temporary or Locum Tenens physician.

Patient Activity

3.1 Finding: The majority of patients were in bed throughout the inspection.

3.2 Finding: Many of the patients who were able to discuss their lives, did report an increase in activity over the last several months.

Facility: Hiram W. Davis Medical Center

Date of Inspection: Monday, November 15, 1999

Time: 7:30 P.M. - 10:30 P.M.

Type of Inspection: Snapshot Inspection, Unannounced

Inspection Focus/Purpose: To review the general conditions of the facility, identify staffing patterns and census and to observe the general activities of the patients.

Sources of Information: Information was obtained during the inspection in the following manner: interviews were conducted with staff and patients, a tour of the units was completed. Observations were made of staff and patient interactions. A patient record was reviewed as well as staff scheduling information.

General Conditions

1.1 Finding: The front entrances to the building were not secured.

Background: Inspectors were able to enter the building during evening hours without difficulty as two of the front entrances were unsecured. Entrance occurred through the front door closest to the parking lot. An inside door, which was locked but had not been pulled shut, allowed greater access into the building. The front doors, difficult to close, had to be forcibly shut in order to be secured. Efforts to use the callbox located outside the main entrance to announce our presence failed as there was not a response to the call after 15+ rings. The two staff members, who came to the first floor to obtain items from the vending machines, did not seem surprised or alarmed that strangers were in the building. This was to the degree that they proceeded to obtain their items before attempting to determine who we were or the nature of our business within the facility.

Recommendation: Increased security measures are needed at this facility including staff training.

1.2 Finding: The facility was clean and well maintained, although there was not adequate storage space.

Background: A tour of the facility revealed that it was well maintained. There was adequate lighting for staff to perform skilled tasks with patients. Several adaptive devices created by the maintenance department were pointed out by staff as aiding them in providing safe care for several patients. It was observed that several of the hall bathrooms were used for storage of wheelchairs and other devices. There was limited storage space for patients' personal items and in several cases items were stacked on the small dresser beside the beds.

Recommendation: **Continue to maintain the facility while evaluating the issue of inadequate storage space.**

1.3 Finding: HWDMC has moved beds for CSH Forensics patients such that they are clustered together in one large room and may be more closely monitored as a group by the required 2:1 CSH Forensics staff.

Background: This moving of patients has helped free up more space in other parts of HWDMC, and more efficiently use staff from CSH for their own monitoring requirements.

Recommendation: **None. This will be followed in future inspections.**

Staffing Issues

2.1 Finding: The use of mandatory overtime for facility staff has been reduced.

Background: Since the last inspection of this facility in July of 1999, staff reported that the use of mandatory overtime has been significantly reduced. This has been accomplished in part by the increased usage of outside agency and pool staff for coverage. Staff mandatory overtime was reviewed for the period between

October 25, 1999 – November 9, 1999. The documentation indicated that there was not any "stay-over" required by RNs. There were, however, four occasions for LPNs but no one did more than one shift during that period. There were twenty-seven occurrences for CNAs with only one individual doing more than one mandatory stay over which was noted as voluntary overtime. Even though this continues to represent a significant amount of mandatory overtime, this is a significant improvement from earlier when the average for staff interviewed was 2.6 shifts or 21 hours of mandatory overtime in a single two week pay period.

Recommendation: Continue to monitor and develop methods for reducing mandatory overtime.

2.2 Finding: Staff reports that the response time for the on-call physician was good.

Background: Staff was asked to rate the response time of the on-call physician. It was reported that the average time for responding to a page was less than ten minutes and that the physician could arrive on-site within a half-hour. Currently, it seems that on-call is being provided primarily by one physician. Staff were not asked to page the physician due to the time of the inspection.

Recommendation: None, this as reported is a good response time.

2.3 Finding: There was not any documented evidence of consultation by the psychiatrist from Central State Hospital regarding a long-term patient transferred from that facility to an acute bed.

Background: A record of a patient transferred from Central State Hospital was reviewed. This patient had initially required 2:1 staffing, which was later reduced to 1:1 monitoring, due to his significant history of aggressive behavior and disorganized thinking. One area explored, while reviewing the record, was the continuity of care for this 67 years old male with a significant and chronic history of mental illness. The record did not indicate that the patient had been seen by his attending Central State psychiatrist during the nineteen days since his admission to HWDMC. One note related that a discussion had occurred between physicians but this was not elaborated on in any manner. Staff were not able to identify whether the patient had actually been seen through any of the facility's documentation methods for significant events. It was reported that a HWDMC staff member who had been involved in the patient's monitoring, participated in a team meeting at CSH to discuss the decrease in aggression experienced while the patient was at Hiram W. Davis Medical Center.

In addition, a transfer consultation note for this patient had indicated that at the time he was being transferred he was on a relatively high dosage of Librium but this was not noted as continued at the time of his admission. Staff were requested to assist in the location of either a consult note or explanation regarding this situation but the rationale for discontinuation was not evident. Staff interviewed indicated that consult notes were not entered into the record at the facility but became a part of the "home-record" (in this case Central State Hospital's record) for the patient(s). As two separate and distinct facilities, it would be a reasonable practice for "outside" consultation to be a contact of record for HWDMC.

Recommendation: The facility should review its current policies and procedures regarding documentation of the continuity of care for transferred patients.

2.4 Finding: HWDMC is currently using a temporary or Locum Tenens physician.

Background: HWDMC recently lost one of its two family practice physicians to Southside Virginia Training Center. In the short term, they have used a Locum Tenens Physician. Discussion with the facility director immediately following this inspection revealed that HWDMC has hired a board certified Internal Medicine physician who will be starting December 22, 1999. This is promising, the facility is greatly anticipating his arrival. In general the use of temporary physicians in any facility is seen as less than optimal for the patients and their continuity of care. HWDMC is fortunate to have been able to hire a qualified physician in a relatively short period of time.

Recommendation: None. This will be followed in future inspections.

Patient Activity

3.1 Finding: The majority of patients were in bed throughout the inspection.

Background: Staff was observed providing for routine evening care of patients in preparation for the night. The majority of patients were sleeping due in part to the timing of the inspection. Staff noted that with an increase in daytime activity for patients, more were tired earlier in the evening. Music or televisions were on in many of the "socials" and patients interviewed reported enjoying the stimulation.

Recommendation: **None. Given the time of day this was not inappropriate activity.**

3.2 Finding: Many of the patients who were able to discuss their lives, did report an increase in activity over the last several months.

Background: Several months ago HWDMC hired a new rehabilitation director who has worked together with the nursing director and staff to increase the opportunities for meaningful activity for these patients. Preliminary information reveals that this has been successful, however actual data was not available during this inspection due to the late hour of inspection.

Recommendation: Continue to pursue meaningful activities and active treatment for these deserving patients.